THE PROFESSIONAL NURSES' PERCEPTION OF WORKING IN REMOTE RURAL CLINICS IN LIMPOPO PROVINCE

by

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Submitted in partial fulfilment of the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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November 2006

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DECLARATION

I declare that THE PROFESSIONAL NURSES' PERCEPTION OF WORKING IN REMOTE RURAL CLINICS IN LIMPOPO PROVINCE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE DATE ……

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ABSTRACT

The purpose of the study was to explore and describe the professional nurse's perception of working in remote rural clinics in Limpopo Province.

The research design was qualitative, exploratory, descriptive and contextual. The research population was the professional nurses working in remote rural clinics in Limpopo Province. Purposive sampling was used and data collected by means of tape-recorded in-depth semi-structured individual interviews.

The study revealed that the professional nurses perceived working in the remote rural clinics both positively and negatively and had concerns.

KEY CONCEPTS

District health system, perception, phenomenology, primary health care, professional nurses, qualitative research, remote rural clinics.

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to the following persons:

- God, my Saviour, for the strength and ability to undertake this study
- My supervisor, Professor TR Mavundla, for his guidance and support throughout the study
- The primary health care coordinator, Mrs MJ Manchidi, for permission to conduct the study
- My beloved husband, Gosebo, for encouraging and motivating me
- My three young sons, Hlabirwa, Moroaswi and Monare, for their love, support and help during my studies
- My aunt, Mologadi, for her love and looking after my family
- My best friends, Sebolelo and Marakgodi, for their prayers, support and friendship
- The librarian, Ms T Burger, for assisting me with the literature search
- The respondents, for their time, input and sharing
- Ms IM Cooper, for critically and professionally editing the manuscript for language and content

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CHAPTER 1

Orientation

1.1 INTRODUCTION

Health care has undergone a paradigm shift since the late 1900s. The 1978 Alma Ata Declaration (World Health Organization (WHO 1978)) stressed that primary health care (PHC) services need to be restructured. Restructuring of PHC involves the whole system including the health personnel who need to be equipped and trained in PHC-related issues. Moreover, restructuring also emphasises equal and rational allocation of human and material resources. After the 1994 democratic elections in South Africa, the government supported the restructuring of health services by emphasising PHC rather than secondary health care (Department of Health 1997:21).

Rural health clinics were established to assist disadvantaged and remote communities and bring health services nearer to them. They are important PHC facilities that need restructuring in order to meet the communities' health needs.

According to Dennill, King and Swanepoel (1999:6), the PHC strategy should be based on the principles of equity, accessibility, availability, effectiveness and efficiency. They add that the success of the PHC strategy lies in a comprehensive approach based on meeting the basic needs of the people and community ownership of its health services. Although the principles of PHC are emphasised there are still areas for improvement in rural clinics, especially regarding the allocation of resources (Bushy & Leipert 2004:1).

The researcher is of the opinion that achievements and areas for improvement in rural health clinics vary according to the uniqueness of each clinic and the context in which it operates. This study therefore focused on professional nurses' perception of working in remote rural clinics in Limpopo Province. The researcher found no previous research on rendering PHC on health professionals', especially nurses' perceptions of working in this environment. The study will help to guide managers to render appropriate support to professional nurses working in remote rural clinics.

1.2 BACKGROUND TO THE STUDY

After the 1994 elections, the South African government introduced a district health system (DHS) in order to deal with problems of apartheid. This was done in order to distribute health resources equally to match the needs of a democratic South Africa. The DHS was seen as a vehicle for providing quality PHC to everyone in a defined geographical area. In this system, individuals, communities and all health care providers in the area participate together in improving their own health (Unger & Kriel 1995:115).

The DHS was introduced to meet the health needs of all the people in South Africa (ANC 1994:42). In the past health care services were fragmented, inefficient and ineffective, and resources were mismanaged and poorly distributed. The situation in rural areas was particularly unsatisfactory. Patients/clients were not cared for holistically and comprehensively and PHC services were not rendered. The DHS was also aimed at involving the local community in health care decisions and improving the service delivery.

This study was conducted in a remote rural clinic situated in Limpopo Province. Limpopo Province has six districts, of which two are nodal points, namely Bohlabela and Sekhukhune. The study was conducted in Makhuduthamaga, one of the five municipalities of Sekhukhune district. The Makhuduthamaga municipality has seventeen clinics, situated far apart. The nearest clinic is situated six kilometres (km) away from the office of the PHC supervisor, and the furthest is 53 km away.

Rural health clinics are health facilities that emphasise prevention, promotion, rehabilitation and curative health care services rather than hospitals that emphasise curative services only (Dennill et al 1999:14). These clinics are intended to improve access to health care services for rural residents living in designated shortage areas (Klein 1999:36). According to the American Academy of Physician Assistants (2005:3), the rural clinics program is an essential component of rural health care delivery today because it has been successful in delivery of health care to previously underserved areas. DENOSA (2005:131) found job satisfaction and greater autonomy among professional nurses presently working in rural clinics.

Apart from rural health clinics' success, there are areas that need improvement in order to reach the goals of PHC facilities. The first area that needs improvement is the shortage of health professionals like doctors, pharmacists and professional nurses at national, provincial and district levels. Thipanyane and Mavundla (1998:28) found a shortage of professional nurses working in two rural districts of the Eastern Cape Province, as well as overcrowding of clients wanting to be seen by nurses. Gilliomee (1999:103) found a shortage of nurses in an Intensive Care Unit (ICU) in Gauteng. Currently, the National Department of Health is working on the issue of shortage of health professionals by retaining the available staff by giving them monetary incentives and recruiting more staff (Hegney, McCarthy, Rogers, Clark & Gorman 2002:128).

According to MacLeod, Kulig, Stewart and Pitbledo (2004:1), in Canada, professional nurses are the health professionals that make PHC services work, especially in rural clinics where there is a shortage of medical doctors. For example, in one clinic one professional nurse provided the services because of its geographical location and substandard infrastructure. Rogers (2002:31) holds that the shortage of nurses in rural areas is a community issue that needs to be addressed by recruiting people living in an area.

The shortage of professional nurse in rural areas is a widespread problem. According to Hegney et al (2002:129), the shortage of sufficient professional nurses in Queensland, Australia has significant repercussions. The short-term solution of utilising casual agency nurses compromises the provision of cohesive health care for remote rural people across the health care continuum and inflates health care budgets. Without the professional nurses, many rural health care services would not be able to provide health care at all. There is an urgent need to recruit and retain more skilled professional staff. Table 1.1 below shows the staffing pattern of professional nurses per clinic in Makhuduthamaga municipality, Sekhukhune district.

Table 1.1 Distribution of professional nurses in Makhuduthamaga clinics

Name of clinic	Number of professional nurses
Dichoeung	3
Marulaneng	4
Manganeng	3
Schoonoord	3
Tshehlwaneng	2
Mamone	5
Marishane	4
Phaahla	4
Probeerin	5
Magalies	4
Setlaboswana	3
Mampana	1
Phokwane	3
Klipsruit	4
Rietspruit	3
Eensaam	2
Phatantsoane	2

The introduction of free health care services in clinics in South Africa increased the workload of professional nurses in rural clinics. Since most rural communities are poor, they utilise the available clinics because they cannot afford to pay for medical aid and have no other option of health facilities (Department of Health 1997:2).

In Niger, Meuwissen (2002:305) found a deteriorating health system with practically no drugs available in rural health centres, irregular supplies and insufficient equipment resulting from the implementation of free health services. Although the integration of PHC services is a way of optimising the use of scarce resources and responding more effectively to people's needs, it increased professional nurses' workload because they need to be multiskilled to render quality integrated PHC services (WHO 1996:5).

Integration aims to increase consumer satisfaction with health care services, reduce differences in the access and utilisation of services between geographical and socio economic groups, leading to greater equity in health care.

Netshandama, Nemathaga and Mahoko (2005:64) emphasise that integration of PHC services adds to the professional nurses' heavy workload because of the multiple work roles they perform.

In a study of professional nurses' experience of nursing mentally ill people in a general hospital setting, for example, Mavundla (2000:1567) found that nurses in a particular general hospital were nursing more patients than they were supposed to nurse. In the United Arab Emirates, Harrison (1996:65) found there is no designated patient/client load in rural clinics. The utilisation of rural health clinics is determined by the number of communities and the number and type of health care facilities available in an area.

Another problem that needs attention is accessibility of clinics. In some cases, geographical location and means of transportation prevent access to rural clinics. For example, the roads to the clinics are not tarred, but gravel and dongas. During the rainy season, then, the clinics are inaccessible. The main transportation is buses, which run at irregular times. Often it is difficult to refer patients to the next level of care because rural clinics are located far from the main road (Bushy et al 2005:8). Rogers (2005:34) found that access to rural health services is difficult because rural people cannot afford the available transportation, especially in low-income groups. This could lead to lack of continuity of PHC care (Harrison 1996:59).

Although the Constitution of the Republic of South Africa (1996:13) emphasises that every person has the right to sufficient basic needs, including pure water supply, electricity and adequate housing, some rural clinics lack these basic needs.

- Water supply

There is shortage of water supply in some of the rural clinics. Shortage of water compromises the health of the community and the health workers (Department of Health South Africa 1997:129).

- Electricity supply

Several of the rural clinics in the area of the study do not have electricity. Clinics without electricity are unable to function effectively and efficiently to render 24-hour service (Sinay 2001:243).

- Inadequate buildings

Most of the clinics were built over thirty years ago. Some are very small, without adequate consulting and maternity rooms, which compromises privacy. Table 1.2 below shows the availability of basic needs (infrastructure) in the rural clinics in Makhuduthamaga.

Table 1.2 Infrastructure of clinics

Infrastructure	Number of clinics	Percentage
Total clinics	17	100%
Electricity availability	14	82%
Water supply	15	88%
Telephone	09	52%
Sanitation	15	88%
Upgraded clinic	06	35%

This background led the researcher to undertake this study and formulate the research problem.

1.3 STATEMENT OF RESEARCH PROBLEM

The researcher found that little research has been conducted on the experience of nurses working in remote rural clinics. Most studies in this area were conducted in Australia, the USA and Canada. The researcher is of the opinion that this study would provide first-hand information on the phenomenon.

Previous research on rural clinics focused mainly on PHC facilities and the rendering of PHC services (Department of Health 2001:4). This led to the following research question:

> What is the perception of the professional nurses working in remote rural clinics in Limpopo Province?

1.4 OBJECTIVES OF THE STUDY

The study aimed to

- explore and describe the professional nurses' perception of working in remote rural clinics in Limpopo Province (Phase 1)
- develop guidelines for the support of professional nurses working in remote rural clinics (Phase 2)

1.5 PARADIGMATIC PERSPECTIVE

The qualitative paradigm is a research approach according to which research takes the insider perspective on social action as its departure point (Babbie & Mouton 2004:53). Qualitative researchers attempt to study human action from the insider's perspective.

According to Polit and Hungler (1993:442), a paradigm is a way of looking at natural phenomena that encompasses a set of philosophical assumptions and guides one's approach to inquiry. This study adopted Neuman's systems theory as a paradigmatic perspective (Botes 1995:110; Creswell 1998:78). Neuman's systems theory reflects a person as a whole person with the internal and external environments.

1.5.1 Meta-paradigm

According to Botes (1995:110), meta-theoretical assumptions address the nature of the reality for the researcher. These assumptions have their origin in philosophy. They are not testable and deal with the human being and society. In this study, the researcher's values and assumptions stemmed from her professional work and working with families and communities. Creswell (1998:76) states that in qualitative research, there are multiple realities, such as the reality of the researcher, those of the individuals being investigated and those of the reader or audience interpreting the findings of the study. In this study the researcher adopted Neuman's systems model as the paradigmatic perspective of nursing discipline, dealing with human beings and society (Botes 1995:110; Creswell 1998:78). Stanhope and Lancaster (2000:203) describe a model as "a way of viewing phenomena by describing the relationship between the parts". Neuman's systems model is based on general systems theory, which holds that every organism represents a system, which means a complex of elements in mutual interaction (Stanhope & Lancaster 2000:206). Neuman linked the

four concepts of nursing meta-paradigm, that is, person, environment, health and nursing in the system model.

- Person/Client

A person is usually an aggregate, a population, or an entire community (Stanhope & Lancaster 2004:197). The client system may be individuals, families, communities and the person is in constant interaction with the environment. In this study the person/client is referred to the professional nurses working in remote rural clinics.

- Environment

The environment is "the physical, social and polities surrounding and settings for the aggregate population or the entire community" (Stanhope & Lancaster 2003:197). Stanhope and Lancaster (2003:197) identify three kinds of environment: internal, external and created. The internal environment is made up of all the forces and interactive influences that are solely within the boundaries of the client system.

In this study the environment refers to the clinics where the professional nurses work which are remote and based in Limpompo Province.

- Health

Neuman defines health as "dynamic, with changing levels occurring within a normal range for the person/client system over time" (Stanhope & Lancaster 2003:208). Health is interpreted as the health state of the community of aggregate population. This study considered the health of professional nurses intensively to support them so that they can perform their duties effectively and efficiently.

- Nursing

Nursing is the process or practice interventions that are used to care for the community or person/client (Stanhope & Lancaster 2003:198). In this study, the nursing process is directed and used by the professional nurses working in remote rural clinics to assess, plan, implement and evaluate services rendered to persons/clients and the community when they visit the clinic .

1.5.2 Theoretical assumptions

Theoretical assumptions are testable and offer pronouncements about the research field. These assumptions contain statements about the research field and form part of the existing and accepted theory of a discipline. Researchers must make a thorough study of existing theoretical pronouncements (literature) on the subject under investigation in order to be able to state their theoretical assumptions (Botes 1995:111). Since this was a phenomenological study, the researcher entered the field without any preset theory of reference by using "bracketing" and "intuiting".

Neuman's systems model entails inputs, process and outputs or outcomes. In this study, the inputs were patients, families, communities and professional nurses. Inputs also included policies and procedures used by professional nurses to render services. The process in this study would be available guidelines that address implementation of services to deal with the provision of Primary Health Care services to the individuals, families and communities. Finally the outputs would be the results of such procedures and policies and other benefits achieved by the study, which include guidelines that would support nurses in the provision of health services in remote rural clinics.

1.5.3 Methodological assumptions

The methodological assumptions, how researchers conceptualise the entire research process, emerge from the distinctions about reality, the relationship between the researcher and that which is being researched, and the role of values Creswell (1998:77). In qualitative methodology, the research starts inductively, that is, the initial inductive logic of generating open coding and generating a theory evolves into the deductive process of examining the theory against existing

and new databases. Botes (1995:5) adds that research findings in qualitative studies should be functional and used to improve practice.

In this study the researcher inductively developed categories and themes only after obtaining information from the respondents. The respondents were interviewed about the phenomenon under study without the researcher specifying categories. The methodological assumptions are discussed under the research design, data collection and analysis in chapter 2.

1.6 DEFINITIONS

For the purposes of the study, the following terms are used as defined below:

- Professional nurse. A professional nurse is a person who is registered with the South African Nursing Council (SANC) and "educated to be able to interact with the patient in a goal-directed way in order to assist the patient to mobilise resources in the environment to facilitate a quest for wholeness" (Poggenpoel 1994:54).

- Perception. *Collins English Dictionary* (1991:1156, 1157) defines *perceive* as "to become aware of (something) through the senses, esp. the sight; recognize or observe; to come to comprehend; grasp" and *perception* as "the act or the effect of perceiving; insight or intuition gained by perceiving; the ability or capacity to perceive; way of perceiving; awareness or consciousness; view; the process by which an organism detects and interprets information from the external world by means of the sensory receptors". In this study it refers to the perception of professional nurses working in remote rural arrears.

- Remote rural area. *Collins English Dictionary* (1991:1311, 1356, 1688) defines *remote* as "located far away; distant; far from any centre of population, society, or civilization; out-of-the-way" and *rural* as "of, relating to, or characteristic of the country or country life" compared to *urban*, which means "of, relating to, or constituting a city or town". In remote rural areas, therefore, there are scattered settlements, a high degree of unemployment and poverty, and an ageing population. These areas are also deprived of and dependent on benefits. In this study, the remote rural area is in Limpopo Province.

1.7 OUTLINE OF THE STUDY

Chapter 1 introduced the study and outlined the problem, research design and methodology.

Chapter 2 discusses the research design and methodology.

Chapter 3 discusses the research findings.

Chapter 4 presents guidelines to support professional nurses working in remote rural clinics

Chapter 5 concludes the study, discusses its limitations, and makes recommendations for practice and further research.

1.8 CONCLUSION

This chapter outlined the background to and rationale for the study, including the problem statement and assumptions, described the research approach, and defined key concepts/terms used.

Chapter 2 discusses the research design and methodology.

CHAPTER 2

Research design and methodology

2.1 INTRODUCTION

The study consisted of two phases. Phase 1 explored and described the respondents' perception of working in remote rural clinics in Limpopo Province. Phase 2 dealt with the development and description of guidelines for the support of professional nurses working in remote rural clinics in Limpopo Province to improve practice.

2.2 PURPOSE OF THE STUDY

The purpose of this study was to explore professional nurses' perceptions of working in remote rural clinics in Limpopo Province, Sekhukhune district in one of the five local municipalities. To achieve this purpose, the objectives were to

- explore and describe professional nurses' perceptions of working in remote rural clinics in Limpopo Province
- develop and describe guidelines for the support of professional nurses working in remote rural clinics

2.3 RESEARCH DESIGN

A research design is "a plan or blueprint of how the researcher intends conducting the research" (Babbie & Mouton 2004:74). The researcher chose a qualitative, exploratory, descriptive and contextual design for this study.

2.3.1 Qualitative

According to Burns and Grove (1999:338), a qualitative research design is "a systematic, subjective approach used to describe life experiences and give them meaning". Babbie and

Mouton (2004:270) describe the primary goal of qualitative research as describing and understanding rather than explaining human behaviour.

The differences between quantitative and qualitative study methods involve "trade-offs between breadth and depth. Qualitative studies permit enquiry into selected issues in great depth with careful attention to detail, context, and nuance ... that data collection need not be constrained by pre-determined analytical categories contributes to the potential breadth of qualitative inquiry. Qualitative methods typically produce a wealth of detailed data using a much smaller number of people and cases" (Patton 2002:227).

According to Brink and Wood (1998:337), a qualitative design is "directed towards discovering or uncovering new insights, meanings and understandings. Qualitative research is an in-depth analysis of the problem in order to understand the 'what' and 'why' of human behaviour." Creswell (1994:145) states that qualitative research is interested in means that explain how people make sense (meaning) of their experiences and their views of the world.

In this study, the researcher adopted a qualitative approach to gain insight into the respondents' perceptions of working in remote rural clinics in Limpopo Province by exploring their life-world.

2.3.2 Explorative

Exploratory research examines a new interest or a relatively new topic of study. It is more appropriate for more persistent phenomena (Babbie & Mouton 2004:79). Exploratory studies look for new knowledge, new insights, new understanding and new meaning. A holistic approach is used in an exploratory design. In this study, the focus was on the respondents' perceptions of working in remote rural clinics as well as the environment where they work. Researchers use an exploratory design to discover new meaning or new understanding with the participants (Brink & Wood 1998:312). This study explored the respondents' perceptions of working within the context of remote rural clinics in the Limpopo Province.

2.3.3 Descriptive

Once the researcher had explored the respondents' perceptions of working in a remote rural clinic, it was necessary to describe in detail what was observed. Descriptive research is intended to gain more information about the characteristics of a particular field of study. This approach can be used for various purposes, such as to provide a picture of a situation as it naturally happens, to develop theory, to identify problems in order to justify current practice, and to determine what others in similar situations are doing (Burns & Grove 1999:92). The researcher used this design to describe

- the respondents' perceptions of working in remote rural clinics in Limpopo Province
- guidelines for the support of professional nurses working in remote rural clinics

2.3.4 Contextual

Research findings need to be contextualised within the parameters of the phenomenon studied. Contextualisation refers to "a holistic research strategy of qualitative paradigm" (Babbie & Mouton 2004:272). The aim in qualitative research is "to describe and understand events within the concrete, natural contexts in which they occur" (Babbie & Mouton 2004:272).

According to Botes (1995:6), no research is value free because values direct human activities and thinking. Therefore researchers must take cognisance of the values within a certain temporal-spatial context, because human activities can only be understood in the temporary-spatial context, and especially the value context in which they occur. Moreover, these characteristics influence the research context and design.

2.4 RESEARCH METHODOLOGY

Phase 1 of the study entailed exploring of the respondents' perceptions of working in a remote rural clinic in Limpopo Province. Phase 2 entailed the development and description of guidelines for the support of professional nurses working in remote rural clinics.

2.4.1 Phase 1: Exploration of the respondents' perceptions of working in remote rural clinics

In this phase the researcher collected data. Prior to data collection, certain research formalities had to be followed, including ensuring appropriate ethical standards, identifying the population, and drawing an adequate sample from the entire population.

2.4.1.1 Ethical considerations

The researcher requested and obtained permission to conduct the study from the Primary Health Care (PHC) coordinator of the local municipality where the study was to be conducted. In a covering letter, the researcher explained the purpose of the study and the respondents' rights, including the right to terminate participation at any time should they so wish. The letter also requested permission to use a tape recorder during the interviews. The respondents gave informed consent by signing the letter. Throughout the study the researcher upheld the following principles:

- Beneficence

The principle of beneficence encompasses the responsibility to do no harm to the participants, psychological harm. To avoid psychological harm to the respondents, the researcher carefully considered the phrasing of questions and provided her contact details (Polit & Hungler 1997:356). The researcher assured the respondents that their participation and the information provided would not be used against them in any way (Polit & Hungler 1997:356). Moreover, the respondents were not coerced into providing information that might have caused them emotional distress.

- Respect for human dignity

The principle of respect for human dignity includes the right to self-determination and the right to full disclosure. The principle of self-determination means that respondents have the right to decide voluntarily whether or not to participate in a study without the risk of incurring any penalty (Polit & Hungler 1997:358). Respondents also have the right to terminate their participation at any stage without fear of being penalized (Babbie & Mouton 2004:521).

The principle of full disclosure obliges the researcher to describe fully the nature of the study and the respondents' right to refuse participation. In this study, the respondents were fully informed of the nature and purpose of the study and that participation was voluntary. They then signed the consent form if they agreed to participate (Polit & Hungler 1997:359).

- Justice

The principle of justice includes the right to fair treatment and the right to privacy. Participants should be treated fairly before, during and after the study. Even participants who do not complete the study should not be discriminated against (Burns & Grove 1999:165). The selection of participants should be based on the inclusion criteria prescribed for the study and not the researcher's preference (Burns & Grove 1999:165). In this study, only professional nurses working in remote rural clinics in the Makhuduthamaga municipality, Sekhukhune district of Limpopo Province were interviewed.

Privacy should be maintained throughout the study until completion of all research processes to be followed. Privacy goes hand-in-hand with confidentiality. Information obtained from participants should not be communicated to others by any means (Polit & Hungler 1997:363). The researcher assured the respondents at the time of signing the consent that all information would be treated as strictly confidential and would not identify them in any way.

2.4.1.2 Population and sampling

Babbie and Mouton (2004: 173) define a population as "the theoretically specified aggregation of study elements". Parahoo (1997:218) describes a study population as the total number of units from which data can potentially be collected. The units may be individuals, organizations, events or artefacts. In this study, the population comprised professional nurses working in remote rural clinics in Limpopo Province.

2.4.1.3 Sampling criteria

A research population includes all units from which data can be collected, and a sample is a proportion or subset of the population (Parahoo 1997:218). A carefully selected sample can provide data representative of the population from which the sample is drawn. According to Polit and Hungler (1997:174), a sample is "a subset of the entities that make up the entire population". For a representative sample to be drawn, a researcher should make the sampling criteria known before data collection begins. Burns and Grove (1999:227) describe sampling criteria as "the characteristics that are essential for inclusion in the target population". To be included in this study, the respondents had to meet the following inclusion criteria:

- Gender

Respondents had to be professional nurses working in remote rural clinics in Limpopo Province. Both male and females professional nurses had an equal chance of being included. However, no male professional nurses volunteered to participate in this project. In South Africa, there are few male nurses because they are either given excellent salary packages by occupational health departments or migrate overseas for better salaries.

- Age

There was no age limit, as long as the respondents were professional nurses. The age of currently employed professional nurses ranges from 20 to 60 years.

- Language

Language was important because South Africa is a multi-racial, multi-lingual country. Sesotho, Venda and Sepedi are the common indigenous languages of the Limpopo Province. Professional nurses who could communicate in English or any of the three indigenous languages concerned were invited to participate.

- Rank

The respondents had to be professional nurses, irrespective of specialty or expertise.

- Working experience

Working experience of two years or more was a strong recommendation. This was important to gain sound, rich perceptions of working in a remote rural clinic in Limpopo Province.

- Qualifications

In South Africa, an entry-level post, which qualifies one to be a professional nurse, is a diploma or three- or four-year degree awarded by an accredited institution. All professional nurses with various qualifications were included in the study.

2.4.1.4 Sampling technique

Purposive sampling technique was appropriate because the researcher knew the respondents and their characteristics. In purposive sampling, rich information rather than the number of respondents is important (Polit & Hungler 1997:179). In addition, the researcher knew that the respondents who met the prescribed criteria were knowledgeable about the phenomenon under study.

2.4.1.5 Data collection

Data was collected by means of in-depth, semi-structured, individual phenomenological interviews and observations in the form of field notes.

According to Babbie and Mouton (2004:289), an individual interview is an interaction between an interviewer and an interviewee in which the interviewer has a general plan of inquiry but not a specific set of questions that must be asked in a particular order. It is flexible and continuous rather than prepared in advance like other data-collection methods.

2.4.1.5.1 In-depth phenomenological interviews

Phenomenology is a holistic approach and studies the lived daily experience. It is a systematic, critical investigation of a phenomenon (Streubert & Carpenter 1995:35). Only one open-ended question was asked. The interviews were conducted in the respondents' language of choice, which in this case was English. All the respondents were asked the following question: *What is your perception of working in remote rural clinics?*

The respondents felt comfortable with being interviewed in their working environment as the researcher could observe the environment in which they worked. An in-depth semi-structured interview was preferred because it enabled the researcher to determine whether the respondents understood the questions. The researcher was able to observe the respondents' understanding, degree of cooperativeness, and life style (Polit & Hungler 1997:259).

The researcher used facilitative communication skills to encourage the respondents to talk about their perceptions. The researcher adopted Mavundla's (2000:15-21) model for facilitative communication. This model assumes that facilitative communicators are created; in other words, in order for people to facilitate communication, they have to be taught. This model was applied as follows in this study:

- *Skills teaching*. The researcher had no psychiatric nursing training at the time of fieldwork, and needed to be taught how to facilitate communication in an interview. Therefore she attended a workshop on facilitative communication skills.

- *Skills practice.* Having learned facilitative communication skills, the researcher put them into practice them in a pilot study. Brink and Wood (1998:376) describe a pilot study as a miniature version of a research study that resembles the main study in every detail. According to Burns and Grove (1997:53), a pilot study is conducted in preparation for the main study. The researcher conducted a pilot study to identify problems in the research design, refine the data-collection instrument and gain experience in interviewing. Data collected was tape-recorded with the permission of the participants. Two pilot interviews

were conducted, transcribed verbatim and shared with the supervisor. Learning gaps were identified and the researcher prepared for the main interviews.

- *Skills application.* This stage involved conducting interviews with the respondents. The researcher used the following facilitative communication skills:

  - *Reflecting*

    According to Streubert and Carpenter (1995:258), reflecting refers to the belief that the language individuals use to describe an experience reflects the experience being described and also other experiences in the individual's life. It is believed that many explanations exist for any one observation. The researcher used reflecting to ensure that the respondents understood what she said as well as that she listened intently to the respondents.

    According to Streubert and Carpenter (1997:260), when researchers and participants engage in reflecting, they probe for the reflexive bases of the data generated. In this study, the researcher used reflecting to ensure correct interpretation and meaning of the data.

  - *Probing*

    According to Polit and Hungler (1997:265), probing is the technique used by researchers to elicit more useful or detailed information from participants than was volunteered in the initial reply. Probing assists in successful collection of interview data provided the researcher has the necessary skills. In this study, the researcher probed by encouraging respondents to talk openly about their perceptions of working in remote rural clinics.

2.4.1.5.2 Field notes

In addition to the interviews, the researcher recorded field notes. Field notes refer to documents generated from observations (Streubert & Carpenter 1995:99). Field notes document observations

about the participants. According to Polit and Hungler (1997:272), field notes are categorised according to the purpose they serve during data analysis.

Field notes relieve researchers of having to remember all the events that occurred during the interview and also constitute a written record of the development of the observations and ideas to be used in future publications of the research findings and methods (Wilson 1989:435). In this study, the researcher made field notes during the individual interviews.

Field notes are descriptive and reflective (Boglan & Bicklen 1992:108). In this study the field notes described the setting, respondents and actions, and captured the researcher's ideas and concerns. The researcher used the field notes together with the verbatim transcriptions of the interviews in data analysis. The field notes consisted of observational, theoretical, methodological and personal notes.

(a) Observational notes

Observational field notes are a description of experiences obtained through watching and give an account of what happened (De Vos 1998:285). They contain the "who", "what", "where" and "how" of a situation and as little interpretation as possible (Wilson 1989:49). In this study, observational notes described the physical layout of the clinic where the respondents worked. The characteristics of the setting (e.g., overcrowding, availability of adequate nurses and equipment) were part of these notes.

(b) Theoretical notes

Theoretical field notes are self-conscious, systematic attempts to derive meaning from observational notes. For this study, new meanings were inferred and conjectured from interactions with the respondents and new interpretations and definitions formulated from field observations.

(c) Methodological notes

Methodological notes are instructions to oneself, critiques of one's tactics, and reminders about methodological approaches that may be fruitful (Wilson 1989:435). In this study, the researcher noted the procedures and strategies employed. The researcher's conduct was evaluated during the pilot study and the consensus meeting with another researcher who is a qualitative research expert. The supervisor provided the researcher with feedback as well.

(d) Personal notes

Personal field notes are all about one's own reflections, reactions and experiences. In this study, the researcher noted her insights, reactions and thoughts during the interviews.

2.4.1.6 Data analysis

The tape-recorded interviews were transcribed verbatim and analysed together with field notes, using to Tesch's eight-step method (Babbie & Mouton 2004:490; Creswell 1994:155; De Vos 1998:343):

- Get a sense of the whole. The researcher read all the transcriptions carefully and jotted down ideas that came to mind.
- Choose one transcript and go through it, asking what it is all about? The researcher thought about underlying meaning and wrote her thoughts down in the margin.
- Make a list of all the topics. Cluster similar topics together then arrange these groups in columns under major and unique topics.
- Take the list and go back to the data. Abbreviate the topics as codes and write the codes next to appropriate segments of text. See whether new categories and codes emerge.
- Use descriptive words to categorise topics. Group related topics together.
- Make a final decision about the abbreviations for each category and alphabetise the codes.
- Gather data belonging to each category and do a preliminary analysis.

- Identify and reflect on relationships between categories and sub-categories, as these are the themes that form the findings of the study.

The researcher gave the identified coder, who is a community health nurse practitioner and knowledgeable in the field of qualitative research, the protocol for the method used, together with transcriptions and field notes. Categories of data were formed and codes allocated to the categories (Creswell 1994:154). After data analysis the researcher and the independent coder met and reached consensus on themes.

2.4.1.7 Literature review

According to Burns and Grove (1999:107), the purpose and timing of a literature review vary based on the type of study. In phenomenology studies, the literature should be reviewed after data collection and analysis so that the information in the literature will not influence researchers' objectivity. After data analysis the findings are compared with information from the literature to determine similarities and differences. Lastly, the findings are combined to reflect the current knowledge of the phenomenon.

2.4.2 Phase 2: Description of guidelines for the support of professional nurses working in remote rural clinics

The researcher used the data collected as the basis for describing guidelines for the support of professional nurses employed in remote rural clinics of the Limpopo Province. The researcher used deductive reasoning to arrive at the guidelines. Literature was reviewed to enhance the trustworthiness of the guidelines.

2.5 MEASURES TO ENSURE TRUSTWORTHINESS

To ensure trustworthiness, the researcher used Lincoln and Guba's method (1985:329), which describes the following criteria for establishing trustworthiness: truth-value, applicability, consistency and neutrality. These criteria were applied throughout the study.

2.5.1 Truth-value

Truth-value assists the researcher to establish confidence in the subject and the context in which the research is undertaken. According to De Vos (2001:331), credibility is used as a strategy to uncover truth-value.

In this study, truth-value asked whether the researcher established confidence in the truth of the findings. Truth-value was enhanced by the strategy of credibility (Krefting 1991:214-215). Credibility was achieved through the following procedures:

2.5.1.1 Prolonged engagement

The researcher invested sufficient time in establishing rapport and trust with the respondents, most of whom she knew. The researcher has worked as a clinic supervisor for twenty-four (24) years and is familiar with the context of the study. The interviews were conducted until data saturation occurred (Babbie & Mouton 2002:277).

2.5.1.2 *Triangulation*

In this study, in-depth individual interviews, field notes, literature review, deductive reasoning, analysis and synthesis were used as data-collection methods. The research design was qualitative, explorative, descriptive and contextual. Follow-up interviews were conducted for clarification. Measures for ensuring trustworthiness were applied throughout study to render the research findings scientific.

2.5.1.3 Persistent observation

The researcher observed the respondents persistently and made field notes during all the interviews. Lincoln and Guba (1985:301) refer to this as establishing rapport.

2.5.1.4 Referential adequacy

The researcher took field notes and tape-recorded all the interviews. The researcher then transcribed all the interviews verbatim. A literature review was done to contextualise the findings within existing research.

2.5.1.5 Authority of the researcher

The researcher underwent training in research methodology and was supervised by an experienced qualitative researcher who has a doctorate in nursing. The researcher had the authority to conduct and complete a qualitative research study.

2.5.1.6 Peer debriefing

Peer debriefing refers to discussing findings with an experienced colleague. In this study the researcher was assisted by the supervisor to focus the study. A colleague experienced in qualitative research and research methodology confirmed the findings of the study.

2.5.1.7 Structural coherence

This study focused on the respondents' perceptions of working in remote rural clinics of the Limpopo Province.

2.5.1.8 Member checks

The researcher checked the data collected with the participants continuously to confirm it. A literature review was conducted to link the findings with previous research. A tape recorder was used to capture the interviews.

2.5.2 Applicability

Applicability refers to the extent to which the findings can be applied to other contexts or with other participants (Lincoln & Guba 1985:290). In this study transferability was used to ensure applicability.

Transferability refers to the extent to which the findings can be applied in other contexts or with other participants (Babbie & Mouton 2004:277). Streubert and Carpenter (1995:26) describe transferability as the generalization of the data in quantitative studies; that is, the extent to which the findings can be transferred to other settings or groups. In qualitative research, generalisation is not important because data will not always be the same in similar settings and even if the study could be repeated using the same participants, the findings might not be the same as in the previous one (Babbie & Mouton 2004:277).

The respondents' perceptions of working in remote rural clinics in Limpopo Province cannot be transferred to other contexts if the aim is not to identify similarities and differences between different contexts (Babbie & Mouton 2004:277).

2.5.3 Consistency

Consistency of data refers to whether the findings would be consistent if the inquiry was replicated with the same participants or in a similar context (Krefting 1991:216-217). In this study consistency assessed the extent to which using the same research participants and methods in a similar context would produce the same results.

Dependability was used to ensure consistency. Dependability tries to account for changing conditions in the phenomenon under study. It represents a set of assumptions different from those of reliability (Marshall & Rossman 1995:145). According to Babbie and Mouton (2004:2787), dependability indicates that if it were to be repeated with the same participants in the same context, the findings would be similar. There is no credibility without dependability (Lincoln & Guba 1985:290; Babbie & Mouton 2004:278). Scrutiny of the data and relevant supporting documents by

an external reviewer ensures dependability (Polit & Hungler 1997:255). In this study, the researcher used an independent expert who is experienced in qualitative research methodology.

2.5.4 Neutrality

Neutrality refers to the extent to which the findings of an enquiry are determined by the participants and the conditions of the inquiry and not by biases, motivations, interests or perspectives of the inquiry (Lincoln & Guba, 1985:290). In this study the researcher avoided bias to ensure the objectivity or neutrality of the data (Polit & Hungler 1997:255).

The researcher entered the field with no preconceived ideas or subjectivity. The following approaches facilitated neutrality:

- Establishing an audit trail by keeping personal notes in a diary during the interviews
- Description of the methods used during data collection and literature control
- Using an independent coder and meeting with the independent coder to discuss and reach consensus on the findings.

2.6 CONCLUSION

This chapter discussed the research design and methodology, including the data-collection methods, measures for trustworthiness, and ethical standards. Chapter 3 presents the research findings and literature review.

CHAPTER 3

Research findings and literature review

3.1 INTRODUCTION

This chapter presents the research findings with reference to the literature reviewed in order to contextualise the findings. During data collection and analysis, three themes emerged:

- Positive perceptions of working in remote rural clinics
- Negative perceptions of working in remote rural clinics
- Respondents' concerns

3.2 SAMPLE

The sample comprised eight (8) professional nurses who volunteered to participate in the study and be interviewed on their perceptions of working in remote rural clinics. Data saturation occurred in the fifth interview, but the researcher continued interviewing all the respondents.

Table 3.1 below provides a description of the respondents according to gender, age, professional qualifications and experience of working in rural clinics.

Table 3.1 Respondents' gender, age, qualifications and experience

Respondent No.	Gender	Age	Professional qualifications	Years' experience
1	Female	54 years	General nurse and midwife	8 years
2	Female	47 years	General nurse, midwife, community nursing science, primary health care and degree in nursing (BA CUR)	17 years
3	Female	42 years	General nurse, midwife, community nursing science, nursing administration. Nursing education and degree in nursing (BA CUR)	6 years
4	Female	48 years	General nurse, midwife, community nursing science, nursing administration and primary health care	22 years
5	Female	52 years	General nurse and midwife,	6 years
6	Female	43 years	General nurse and midwife, community nursing science and nursing administration	6 years
7	Female	45 years	General nurse and midwife	4 years
8	Female	46 years	General nurse and midwife	4 years

3.3 FIELD EXPERIENCE

The researcher had no difficulty entering the research field. The researcher met with the respondents at the clinics where they work, which are situated far apart. Written permission to conduct the study was granted by the authorities. The authorities seemed interested in the research topic and wished to receive the findings.

The respondents readily agreed to participate in the study and welcomed the researcher warmly. All the respondents gave informed consent to participate voluntarily (see annexure 2 for a consent form).

Pilot interviews were conducted with two respondents who would not form part of the main study. These interviews were conducted to sharpen the researcher's interviewing skills.

In-depth individual, phenomenological, semi-structured interviews were conducted over a period of two months. The researcher applied facilitative communication skills effectively and gathered rich data.

Transcribing and coding was time consuming, but provided good findings.

3.4 THEMES IN THE PERCEPTIONS OF WORKING IN REMOTE RURAL CLINICS

Three main themes emerged from the data collection and analysis, namely positive perceptions, negative perceptions and respondents' concerns. Table 3.2 depicts the themes and categories revealed by the data analysis.

Table 3.2 Themes and categories regarding working in remote rural clinics

3.4.1	Positive perceptions of working in remote rural clinics
3.4.2	Negative perceptions of working in remote rural clinics
3.4.2.1	Poor infrastructure • Structure of the clinic • Water supply and sanitation • Shortage of electricity • Lack of telephone communication
3.4.2.2	Fear of insecurity
3.4.2.3	Shortage of human resources (HR)
3.4.2.4	Shortage of material resources, equipment and supplies
3.4.2.5	Maintenance services
3.4.3	Respondents' concerns
3.4.3.1	Patients staying far from the clinic
3.4.3.2	Youth do not listen when given health education
3.4.3.3	Inactive clinic committee
3.4.3.4	Inaccessibility of the rural clinics
3.4.3.5	Alcohol and substance abuse by youth

3.4.1 Positive perceptions of working in remote rural clinics

Streubert and Carpenter (1995:3) describe perception as "a way of observing and processing what is present to the self". Some of the respondents perceived working in remote rural clinics positively and reported feeling happy, feeling good, enjoying and not finding the work difficult for various reasons (Hopkins & Donrose 2001:4):

> I am very happy to work in the remote rural clinic because it is nearer my home. I am helping my community and involve them during health talks on how to care for themselves and prevent home accidents, as well as not to put medication within children's reach. We attend to the pregnant mothers and teach them on minor ailments related to pregnancy.

> I enjoy working in rural areas because the community in a rural area needs to be taught most things and they have never been exposed to urban life. We do most things on our own and so become more experienced because we do most things on our own. There are no clerical personnel so as a professional nurse you are supposed to do everything like taking patients' history and vital signs on our own; prescribing, dispensing and issuing medication; doing follow-ups and referring patients to hospital, and having to intervene for social needs. We have to participate in different projects with patients and voluntary workers, like supervision of home-based care."

> I have discovered that by working in a rural clinic, you gain more knowledge, especially in some minor ailments and their treatment. We see different types of minor ailments and when we are not sure, we get the protocol and look for the management of that condition. So this means that day-by-day we are gaining more knowledge.

The 1994 reconstruction and development programme (RDP) is aimed at meeting people's basic needs, including the provision of water, electricity, telecommunication, transport, and a clean and healthy environment. Achievement programmes were set for five years. The success of these programmes is essential to achieve peace and security of all (ANC 1994:7).

The Department of Health (1997:129) is responsible for the country's environmental health status and every South African has the right to a living and working environment, which is not detrimental to health and well being. The environment includes safe drinking water. The respondents expressed satisfaction in the working environment as follows:

> To me, it is not that difficult to work in a rural clinic because nowadays the Government has really improved; our clinics are electrified, we have running water in the clinics, so I cannot say it is difficult, and then we have some of things that are needed. We can take blood from our patients or can collect different types of specimen. We have transport like the clinics in urban areas. Nowadays it is not difficult to work in the rural clinics. It is far better compared to previous years, when the specimen were only collected once per week; sometimes we collected specimen and nobody came to collect them. Sometimes our patients had to return several times because there was no transport for the collection of specimen. The staff establishment is okay for me, I don't know about other people. The professional nurses allocated to the clinic are okay.

> I can say the crime rate in our area is low, and we are able to run 24-hour services. The subordinates are cooperative; they work well and do what they are asked to do. The community itself it is all right. We are paid incentives for working overtime and standby.

3.4.2 Negative perceptions of working in remote rural clinics by professional nurses

Some of the respondents reported negative perceptions, saying that it is very hard to work in the remote rural clinics for several reasons. Bushy and Leipert (2004:1) found areas that need improvement in rural health clinics and these vary according to their uniqueness. In this study, five categories were identified.

3.4.2.1 Poor infrastructure

The participants reported negatively about four subcategories of the infrastructure at the remote rural clinics: structure, water supply and sanitation, shortage of electricity, and lack of telephone communication.

- *Structure*

The respondents indicated that the clinics are too small and do not accommodate delivery and other services.

In Canada, MacLeod et al (2004:1) found the remoteness of rural clinics, coping with limited resources and infrastructure, and the retention of nurses as areas of concern. In South Africa, the Department of Health (1997:40) found that the majority of the population has very limited access to any form of services, and considerable inequities and inefficiencies in the distribution of community health resources. In Limpopo Province, few PHC facilities have adequate waiting areas where patients wait for monitoring of vital data before entering the consultation rooms (Mashego & Piltzer 2005:19).

According to the respondents in this study:

> I have a problem concerning the structure of the clinic. The clinic is too small. Itcannot accommodate many clients, so they have to stand outside the clinic and enter one by one.

> The clinic is too small to accommodate us. We have only two consulting rooms, of which we use one and the other is used as a labour ward for consultation.

- *Water supply and sanitation*

The respondents reported that there is a shortage of water in some remote rural clinics. Although the Department of Health (1997:129) is responsible for the improvement of South Africa's environmental health status, to limit the health risks arising from the physical and social environment, many South Africans are without safe drinking water and basic sanitation. The respondents emphasised shortage of water and sanitation as follows:

> Another problem that we have is no water from the taps. Water is a problem.

> We don't have toilets; the pit toilets are full. We use the one that was in use in the old clinic. It is now becoming full. I don't know what will happen at the end of next month concerning sanitation.

- *Power shortages*

The respondents reported a shortage of electricity in some remote rural clinics. A shortage of electricity hinders the effective and efficient rendering of health services.

In a survey on PHC facilities in all the provinces, Reagan, Irlam & Levin (2003:32) found that Limpopo province had the most facilities without electricity while power failures (outages) occurred frequently in all the provinces.

According to one of the respondents,

> Electricity is a problem; it is poor. According to the electricians, the electrical wires are too thin and not powerful enough for a big building, so it is difficult to run the services. Sometimes the power just goes off while you are busy with the patient and with autoclaving and so on.

- *Lack of telephones*

Communication is essential for clients or patients and also for all the members of the multidisciplinary health team (van Rensburg 1996:217). This study found that most of the clinics lacked telephone services:

> Working at a remote rural clinic is a problem because we don't have a telephone. When we want to communicate with the hospital, we cannot. We use our cell phones, but if our cell phones have a problem, we have to use our own money and use the public telephone to communicate with the hospital.

3.4.2.2 Fear of insecurity

Another negative perception of working in a remote rural clinic was fear of insecurity. According to Maslow's hierarchy of needs, security needs are fulfilled after the physiological needs have been met. The professional nurses as human beings also need to be secured, protected and free from fear and anxiety (Jordaan & Jordaan 1989:653).

The respondents expressed fear of insecurity as follows:

> We are supposed to render 24-hour service and then our problem is our safety. We fear for our safety because there is no fence, the security guards have no weapons like guns, and the distance from the house to the clinic is far. We don't know what could happen on the way from the house to the clinic because there is no fence. People's movement in and out of the clinic is not because there is no fence, so we are afraid.

> There is no security, the security guards have no guns, the fence is so low that anyone can jump over it, and the gates are not locked.

3.4.2.3 Shortage of human resources

Staff (human resources) shortages have a negative impact on rural clinics. In Canada, MacLeod et al (2004:3) found that the health of rural communities is partly dependent on a sustained rural health workforce, of which registered nurses are a key component. In many rural communities in Canada registered nurses are the only professional health care providers.

According to the respondents,

> In our clinic, we are only three professional nurses, our head count for the month is about 2000 to 3000.

> We have a shortage of staff. We have one professional nurse, one enrolled nurse and one enrolled nursing assistant. In case of emergency, we find it difficult to cope.

3.4.2.4 Shortage of material resources, equipment and supplies

The study found a shortage of material resources, equipment and supplies, including linen, refrigerators, blood pressure machines, autoclaves, syringes and needles.

According to Reagan et al (2003:26), Limpopo Province, the Eastern Cape and Mpumalanga province had the lowest levels of availability of equipment. A shortage of resources, equipment and supplies compromises the quality of patient care (DENOSA 2005:12).

According to the respondents,

> There is no oxygen and equipment therefore a patient is referred to the hospital without oxygen. Even the ambulance that comes to fetch the patient has no oxygen to continue the treatment. Another problem is a lack of delivery beds. We don't have one to deliver our patients as we are supposed to deliver them. It is difficult to help them on an ordinary couch. We have poor delivery of stocks. Often we find that we don't even have soap for washing or toilet paper after we have given a patient an enema.

> We find that we ordered so many packets for our patients, but the number we receive is much less.

In Niger, Meuwissen (2002:305) reported no drugs available in rural health care centres, irregular supplies and insufficient equipment due to the high utilization of rural health centres.

3.4.2.5 Maintenance services

In this study the respondents reported negatively on the maintenance services. The maintenance staff take a long period to repair damage at the clinics:

> When there are broken windows, it takes a long time for them to be repaired, so we are afraid that people might come and steal clinic property. When you request manpower to repair the windows, they take a long time to come to do the job.

In a survey on national PHC facilities in South Africa, Reagan et al (2003:30) found that over 50% of facilities needed urgent structural repairs, including leaking roofs, broken windows, toilets and floors.

3.4.3 Respondents' concerns

3.4.3.1 Patients staying far from the clinic

Rogers (2002:32) found that barriers to adequate access to rural health care facilities included local lack of specific medical services, fewer health care professionals, difficulty in reaching the facilities, financial constraints and lack of affordable and available transportation. Access to health care facilities varies within rural areas depending on the geographical location.

The respondents expressed concern over TB patients who live ten kilometres from the clinic and need regular follow-up visits and because of a lack of transport cannot be visited. Another cause for concern was patients who had to travel long distances on public transport. Poverty made it impossible for them to come to the clinic on alternate days for dressings. Patients who required daily blood pressure and lived far from the clinic were not monitored.

> There are patients who are home bound who need to be visited by the professional nurses. Even though we have home-based carers, we sometimes find that the professional nurse is needed for supervision. They live far from the clinic and we don't have transport to visit them. Thus, the main problem is transport.

3.4.3.2 Youth do not listen

The respondents expressed grave concern because the youth do not listen when given health education, especially on STIs and HIV/AIDS. The youth believe that they will not get HIV/AIDS,

and do not use condoms. Some indicate that their boyfriends or girlfriends refuse to use condoms; consequently, STIs are rife.

According to Dreyer, Hattingh and Lock (1993:35), health education is one of the important elements of the PHC nurse's educational role. It forms an integral part of the daily functions of the PHC nurse with the following objectives:

- To assist the community to define their own health problems and needs.
- To understand what they can do about the problems with their own resources combined with outside support.

In health education the emphasis is on changing health behaviour. The role and functions of the PHC nurse are to plan, implement, coordinate, supervise and evaluate the programme as well as the outcome of any health education presented.

One of the respondents expressed her concern as follows:

> What I discovered is that when giving heath education to youth, they don't listen. You sometimes overhear them saying It is a waste of time.

Rankin and Stallings (1990:85) state that health education requires an ongoing assessment of the client's attitudes, knowledge and skills because it occurs over a long period.

3.4.3.3 Inactive clinic committee

In this study there was a concern from the participant that the available clinic committee is not active. Sometimes they are called to attend the meeting only two or three members come and the other members report that they are committed.

Bennett, Thetard, Msauli and Rohde (1998:7) state that clinic committees need to be empowered to enhance their participation in health and social development planning. Community participation is a process of interaction between people to achieve a specific goal and ensure the successful development of the community as a whole.

According to one respondent,

> We don't have an active clinic committee. Sometimes only two or a few members come to the meeting; others do not come, saying they are committed.

3.4.3.4 Inaccessibility

According to the WHO (1996:56), accessibility of the health services is one of the principles for successful strategy for implementation of primary health care services. Services must be accessible to all people in terms of geographical situation. The WHO (1996:51) recommends that the distance be five to ten kilometres (5-10 km) and transport should be available. Rogers (2002:34) found that access to rural health services was difficult because many people were unable to afford the available transportation. One of the respondents stated:

> The clinic is far from the main road and many patients travel long distances to reach the clinic, especially those from villages far away. This is a problem for both clients and staff, some of whom come from far away.

3.4.3.5 Alcohol and substance abuse by youth

This study found that there is alcohol and substance abuse by many of the youth. According to Uys and Middleton (1999:403), substance abuse is when the person shows a maladaptive pattern of substance use over a period of more than 12 months, with a resultant failure to fulfil major role obligations, recurrent inappropriate use, legal problems, social and interpersonal problems. Perko and KreigH (1988:181) describe alcohol and substance abuse according to three criteria: dependency, impaired functioning, and duration. Firstly, the individual depends on the substance chosen, engages a repetitive regime despite intoxication, acknowledged harm to self, control efforts and complications or urgency of need to maintain functioning. Secondly, the person identifies impairment in social or occupational functioning produced by repetitive use pattern, disturbed interpersonal and family relationships, poor judgement and impulse control, inappropriate expression of aggression, and illegal or criminal activity, as well as a marked deterioration in physical and psychological functioning. Finally, the abuse requires the disturbance to have existed for at least one month.

Some of the respondents reported the social health problem of alcohol and substance abuse that is rife in the community:

> Here there is a lot of alcohol and substance abuse, even girls are smoking dagga and drinking liquor. Because of abuse of dagga and alcohol, they don't attend school and the crime rate is very high.

3.5 THEORY APPLICATION TO SUPPORT THE FINDINGS OF THE STUDY

This study applied Neuman's systems theory because it adopts a holistic approach to individual clients or groups. The theory is comprehensive and dynamic, and was developed to assist individuals, families and other groups to attain and maintain total wellness by purposeful intervention (George 1990:261).

Neuman's systems theory focuses on the environmental stressors that face professional nurses working in remote rural clinics. The theory focuses on the prevention of stressors and views individuals, groups or communities as open systems interacting with the environment (Stanhope & Lancaster 2003:199, 201). Accordingly, the respondents are a client system in dynamic interaction with the environment. There are primary, secondary and tertiary intervention strategies for the prevention of stressors.

The primary prevention intervention strategy aims at strengthening the lines of defence by reducing risk factors and preventing stress. In this study, providing and improving human and material resources would support and retain the available professional nurses. The improvement of clinic infrastructure includes building new clinics and providing electricity, pure water supply and proper sanitation. Secondary prevention is aimed at strengthening the lines of resistance. In this study, the shortages of human and material resources, equipment and supplies require urgent attention.

According to Stanhope and Lancaster (2004:2001), interventions begin to correct the problem and strengthen the line of resistance to prevent further dysfunction with the client system.

Tertiary prevention refers to the adjustment that takes place as reconstitution begins and maintenance factors move the client back in a circular manner toward primary prevention (George 1990:262). Tertiary prevention is aimed at encouraging individuals or groups to utilise the available coping mechanisms to the fullest to prevent further stressor reactions.

3.6 CONCLUSION

This chapter discussed the findings with reference to the literature review. The study revealed three themes, namely positive perceptions, negative perceptions and respondents' concerns.

Chapter 4 presents the guidelines for the support of professional nurses working in remote rural clinics.

CHAPTER 4

Guidelines for the support of professional nurses working in remote rural clinics

4.1 INTRODUCTION

This chapter describes the guidelines formulated by the researcher for the support of professional nurses working in remote rural clinics. The guidelines cover the support of professional nurses working in remote rural clinics and the development of support mechanisms for them.

4.2 GUIDELINES FOR THE SUPPORT OF PROFESSIONAL NURSES WORKING IN RURAL CLINICS

These guidelines resulted from the findings discussed in chapter 3.

4.2.1 Support of professional nurses working in remote rural clinics

Support of professional nurses working in remote rural clinics encompasses education, visits by supervisors of various health authority levels, delivery of supplies, and meetings. According to ANC (1994:42), there is a need for PHC development within the constraints of existing structures and systems together with changing structures and systems in relation to PHC policy.

4.2.1.1 Negative perceptions

In this study, shortage of infrastructure, including clinic buildings, telephones, water supply, sanitation and electricity, was the most frequently reported negative perception. These negative perceptions hinder the comprehensive rendering of PHC.

4.2.1.1.1 Small clinic buildings, shortage of water, sanitation and electricity

The study found that poor infrastructure impacted negatively on the respondents. According to Unger and Kriel (1995:118), the focus of PHC support should be based on integrated health infrastructure development. Provide the resources to compensate for local inequities in access to

health care. All permanent clinics should have water, electricity and some method of communication (Unger & Kriel 1995:117). The provision of clean water to communities has been one of the most visible and successful initiatives of the RDP and Eskom's electrification programme.

The support of professional nurses related to improving health infrastructure depends on the provision of the following:

- Safe clean water
- Adequate sanitation facilities
- Electricity
- New standardised clinics with more than two consulting rooms

4.2.1.1.2 Staff shortages

The study found serious staff shortages in the remote rural clinics. This needs to be tackled at provincial and district levels. The recruitment, selection and placement of health professionals based on national needs and affirmative action (Department of Health 1997:54). Accordingly, in support of professional nurses working in remote rural clinics:

- Improve the infrastructure of and working conditions in rural clinics first before advertisement and recruitment.
- Motivate and employ professional nurses who live close to the clinics.
- Employ professional nurses in accordance with the rural clinics' needs or workload in order to maintain the equity principle of PHC.

4.2.1.1.3 Shortages of material resources, equipment and supplies

The study found a shortage of material resources, equipment and supplies in the remote rural clinics. When the supplies are ordered, they are delivered after three to four weeks. In some clinics there is a shortage of oxygen cylinders, refrigerators, blood pressure machines and delivery beds. Needles and syringes are delivered after three to four weeks. Shortages of equipment lead

to poor quality nursing care (DENOSA 2005:31). Therefore, the following guidelines are suggested:

- Clinic supervisors to work together (teamwork) with other departments (e.g., pharmacy, procurement and laboratory) for the timely delivery of supplies to avoid shortages.
- Professional nurses at the clinics to increase stock levels of pharmaceutical supplies to avoid shortages of medication.
- Clinic supervisors to justify and requisition equipment based on the head count of the clinic. The number of blood pressure machines to tally with the number of clients seen per day, week, month and/or year.

All health sectors involved in the support of professional nurses working in remote rural clinics should follow the above guidelines.

4.2.1.1.4 Maintenance services

The study found that maintenance staff take a long time to repair damage. Hence the following is suggested:

- Clinic supervisors should visit clinics once a week and identify areas that need maintenance services immediately and requisition repair.
- Clinic supervisors should be sensitive to nurses' maintenance service requests and act promptly.

4.2.1.1.5 Fear of insecurity

In this study, the respondents expressed fear of insecurity. The following guidelines should prevent professional nurses' fear of insecurity in remote rural clinics:

- Install security fences at the clinics.
- Security personnel should be issued with weapons like guns.
- Security guards should control and monitor the in and out movement of outsiders.

4.2.2 Guidelines for the development of support mechanisms for professional nurses

The roles of the health authorities, the supervisors at various level of district, provincial and national vary. Each level of authority has a role in support of professional nurses in remote rural clinics. According to the ANC (1994:43), the National Department of Health is responsible for the health of the whole nation. The provincial health authorities are responsible for controlling all health services and power devolved to district level. The district health authority supports the community health centres and other facilities in the district. Accordingly, the following support mechanisms are required:

- National level to provide support by improving policy on staffing.
- Provincial level to speed up the process of building new clinics, providing adequate pure drinking water and proper sanitation, and advertising posts.
- District health level to investigate and address the shortage of professional nurses working in remote rural clinics.

4.2.2.1 Importance of support mechanisms

Some of the respondents indicated that they receive support from their supervisors and managers. Therefore, it is important for all health sectors and authorities to provide support.

4.2.2.1.1 Environmental support

The provision of safe water, proper sanitation, new spacious clinics, telephones and electricity is essential in supporting professional nurses. Security personnel and high protective fences would allay fear of insecurity.

4.2.2.1.2 Support mechanisms

The respondents expressed various concerns related to their working environment hence the following support mechanisms should be developed to deal with those concerns.

Active clinic committee

An active clinic committee is part of community involvement and participation. Dreyer, Hattingh and Lock (1993:76) describe community participation as "the active involvement of people who live together in some form of social organisation and cohesion, in the planning, operation and control of PHC by using local, national and other resources". Community participation must be active; people have the right and responsibility to exercise power over decisions that affect their lives, and mechanisms must be available to allow the implementation of the decision made by the community. Therefore the following steps are necessary:

- Revitalise available clinic committees to actively perform their functions, so that clinic services can be manned effectively and efficiently according to community needs.
- Conduct regular monthly meetings.

Community participation involves groups with shared needs living in a particular area actively identifying their needs, taking decisions and establishing mechanisms to meet these needs.

Youth not taking the health education of STIs and HIV/AIDS seriously

All stakeholders involved in PHC services should be involved in educating youth about STIs, including HIV/AIDS. This teamwork should involve government organisations, NGOs, community-based organisations and the community themselves in educating the youth. Support mechanisms in this regard include:

- A multidisciplinary approach in educating youth
- Staging health awareness campaigns for the youth in STIs and HIV/AIDS
- Involving youth in health-related issues
- Encouraging the formation of youth groups
- Encouraging youth to participate actively in health-related campaigns like condom awareness week and youth days

Patients staying far from the clinic

In this study, the respondents expressed concern over patients who live far from the clinic and need regular check ups and follow-up visits. The following support mechanisms are proposed:

- Providing transport to visit homebound and TB patients who live more than 10 km from the clinic.
- Adopt a multidisciplinary team approach, using social workers and others, to assist in tracing patients for follow-up.
- Supervisors with subsidy vehicles should assist in tracing or doing home visits for clients who live far from clinics.
- Long-term intervention by provincial authorities to provide clinics with transport for effective follow-up of patients.

Unger and Kriel (1995:115) emphasise that holistic, integrated and continuous care can only be delivered under certain structural and organisational conditions. The health facilities need to be readily accessible and each level of the health pyramid should provide a given type of care. Integration of health care services is emphasised because it is holistic care that implies a good knowledge of patients and their social environment.

Alcohol and substance abuse by youth

The respondents reported serious alcohol and substance abuse by youth in the community. The following measures would support professional nurses working remote rural clinics:

- Active multidisciplinary team to address alcohol and substance abuse by youth through health education campaigns.
- Frequent awareness campaigns on alcohol and substance abuse prevention.
- Intensive school health service campaigns by multidisciplinary team on the prevention of alcohol and substance abuse by youth.

4.3 CONCLUSION

This chapter described the policy guidelines for support of professional nurses working in remote rural clinics, particularly to eliminate negative perceptions. The guidelines covered the support of professional nurses working in remote rural clinics, and the development of support mechanisms for them. The guidelines emphasised the importance of support by the various health sectors.

Chapter 5 concludes the study, discusses its limitations and makes recommendations for practice and future study.

CHAPTER 5

Conclusions, limitations and recommendations

5.1 INTRODUCTION

This chapter concludes the study, discusses its limitations, and makes recommendations for practice and further research.

The purpose of the study was to examine professional nurses' perceptions of working in remote rural clinics and to describe guidelines to support them. The researcher chose a qualitative approach and in-depth phenomenological interviews as the data-collection method. The interviews gave the researcher an insight into the respondents' working environment and perceptions. The findings were valuable in developing guidelines for the support of professional nurses working in remote rural clinics.

5.2 LIMITATIONS OF THE STUDY

There were certain limitations in the study. First, the study focused on professional nurses' perceptions of working in remote rural clinics without considering their age gaps, professional qualifications and experience. Secondly, the researcher was a colleague of the respondents and this may have influenced their answers. There were no male respondents and thus no male perception. The study was limited to the Makhuduthamaga local municipality PHC, not the whole Sekhukhune district in Limpopo Province.

5.3 RECOMMENDATIONS

In the light of the findings, the researcher makes the following recommendations for practice and future research.

5.3.1 Support for professional nurses

In order to support professional nurses working in remote rural clinics and overcome any negative perceptions, the following steps should be taken:

- Improvement of health infrastructure by provincial health authorities level and provision of transport.
- District or local health authorities should advocate and facilitate the speedy provision of equipment and supplies.
- Provision of transport for follow-up and other home visits to patients.

5.3.2 Team work/multidisciplinary approach to youth education

The respondents expressed grave concern over the health education of the youth. To overcome this concern the following can be done:

- Multidisciplinary teams should be actively involved.
- Health education on STIs and HIV/AIDS campaigns and programmes should be run.
- The participation of youth in all health-related issues, including alcohol and substance abuse prevention, should be encouraged.

The multidisciplinary teams should have a definite vision and shared objective, practise participation and sharing of information, be committed itself and support innovation and initiative.

5.3.3 Further research

Further research should be conducted on

- How professional nurses cope with working in remote rural clinics.
- Male professional nurses' perceptions of working in remote rural clinics.
- Similar studies in other areas and provinces in order to compare perceptions and findings.

5.4 CONCLUSION

This chapter concluded the study, outlined its limitations, and made recommendations for improving practice and for future research. The findings of this study should be valuable in policy making and in nurse education as well.

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Annexure 1

PO Box 1561
Vergelegen B
JANE FURSE
1085
3 October 2005

The Primary Health Care Coordinator
Makhudu Thamaga Subdistrict
Private Bag X431
Jane Furse Hospital
1085

Dear Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I hereby request permission to conduct a research project entitled "The professional nurse's perception of working in remote rural clinics in Limpopo Province".

I am currently an MA Cur student doing research dissertation at Unisa. My supervisor is Professor TR Mavundla of the Department of Health Studies at the university.

The main purpose of this study is to explore and describe the perception of professional nurse's perception of working in remote rural clinics in Limpopo Province and to develop guidelines for the support of these professional nurses depending on their positive and negative experiences.

To complete this study, I need to conduct interviews of approximately 45 to 60 minutes duration with the professional nurses working in remote rural clinics. The interviews will be audiotaped for verification of findings. Only the researcher and an expert in qualitative research who will assist with the analysis of data will share the tape-recorded interviews.

The direct benefit of this study to the subdistrict is that a summary of the research findings will be made available to the subdistrict. The long-term benefits are that the research findings will be used to formulate guidelines for the support of the professional nurse's perception of working in remote rural clinics in Limpopo Province.

I hope that this request will receive your favourable consideration.

Yours faithfully

Mrs RJ Thutse
MA CUR STUDENT, UNISA

Prof TR Mavundla
SUPERVISOR (RN PHD)

Annexure 2

CONSENT LETTER FOR PARTICIPANT

Dear Research Participant

REQUEST FOR CONCERN TO PARTICIPATE IN A RESEARCH STUDY

I am a MA (Cur) student currently enrolled with the University of South Africa (Unisa). I am engaged in a research dissertation titled "The professional nurse's perception of working in remote rural clinics in Limpopo Province".

The objective of this study is to explore and describe the professional nurse's perception of working in remote rural clinics, and to develop guidelines for the support of the professional nurses working in remote rural clinics.

To complete this study, I need to conduct an interview of approximately 45 to 60 minutes duration, which will be audiotaped for verification of findings by an independent qualitative research expert who is a qualitative research expert. In this study, I undertake to safeguard your anonymity by omitting the use of names and places. Confidentiality will be assured by erasing of the taped material on completion of transcription of the tapes.

Only an independent expert on qualitative research and I will share the transcribed tape material. It should be understood that you are under no obligation to participate in this study. You are free to terminate your participation even when the interview has begun.

The direct benefit to you of participating in this study is that you will have the opportunity to verbalise your perceptions of working in remote rural clinics to the researcher. Another benefit is that your experiences will be used to develop guidelines for your support during working remote rural clinics.

A summary of the research findings will be made available to you on request. Should you wish to contact the researcher for any enquiries feel free to do so at the following postal address:

Mrs RJ Thutse
PO Box 1561
Vergelegen B
JANE FURSE
1085

Cell: 0732401732

Thank you

Mrs RJ Thutse
MA CUR STUDENT, UNISA DATE: ……..

Prof TR Mavundla
SUPERVISOR (RN PHD)

…… ……
SIGNATURE OF THE PARTICIPANT DATE

Annexure 4

INTERVIEW

Interviewer:

Good morning mad. We are now going to start our interview. Which language do you prefer to communicate?

Participant:

I prefer English.

Interviewer:

What is your perception of working in a remote rural clinic?

Participant:

First of all I am not saying I have experienced something different from urban clinics. From my experience working at the remote rural clinics, as I was not grown up in the rural area, I have experienced that the community at the rural areas need to be taught most of the things and they have never been exposed to the urban life, so I can say I am enjoying. Coming to the working field at our areas in rural clinics, most of the time when we are not exposed to machinery like the clinics at the urban area, so most of our things we are doing on our own, and then working at rural areas you become more experienced because you do most of the things on your own, like there are no clerical personnel. As a professional nurse you are supposed to do everything like taking patients history, doing vital signs, sometimes on your own, prescribing medication to patients/clients and dispensing and issuing of medication, and follow-ups and refer the patient to the hospital and you have to intervene where social needs are needed, participate with clients on projects, different types of projects.

Interviewer:

I heard you saying you participate with clients on projects. Can you say more on the projects you participate?

Participant:

Greenery projects for the mentally ill patients/clients and other chronic illnesses. we are having the home-based carers and sometimes they need the professional nurse to intervene. The other project is the "love-life", lay counselors and we are having voluntary people that need to be supervised at all times.

Interviewer:

Can you say more on projects?

Participant:

The other projects I have talked about are the home-based carers. The home-based carers are with us in the clinic on daily basis. They report here every morning and then they go out to see patients at home.

Interviewer:

You said that working in the community you have realized that community needs to be taught everything. Can you say more on everything?

Participant:

As I have said, rural community is not like an urban community, people at the rural community, I just wanted to say, I can say 90-99% of the rural people are not educated. So if you come across them and asked some questions may be concerning some illness you find that they don't know, and sometimes if you do some teachings, say like eeh … you educate them on oral dehydration solution, you must do it in talking and practical because if you just tell them you may find out that they didn't know, didn't hear anything at all. You can say you educate them on something and then afterwards you ask some questions only one or two of the group that were participating could answer you. Thus why I am saying you must take your time when dealing with a rural community. So to me it is not a difficult that much to work at the rural clinic because nowadays the government has really improved, our clinics are electrified, we have running water in the clinics, so I cannot say it is difficult, and thee… some of the things that are needed we do have them. We can take blood as we wish from our patients/clients or can collect different types of specimen. We do have transport like the clinics at the urban areas. I cannot say nowadays it is difficult to work at the rural

clinics, if is far much better as compared to those previous years, eeh. The specimen were collected only sometimes once per week, sometimes we were collecting specimen and nobody come to collect them. Sometimes our patients were returned several times telling them that there is no transport for collection of specimen, and thee … as the staff establishment is okay, as to me is okay, I don't know to other people, because the number of professional nurses that are allocated at the clinic to me, according to the population group, is okay, and as we are having subordinates, the enrolled nursing assistants only, they are managing. We cannot say we are short staff, we are managing. It is not difficult to work at the rural areas. To my experience is just that and the office that is managing us, I should think is the one that is doing more. We communicate with the office telephonically and what we are saying they take into consideration and the supervisor that are working with us, I can say they are trying their level best, thus why I am saying it is not difficult to work in the rural clinic. Even though sometimes experiencing something like the patients that are coming from far travelling on public transport, that needs to be seen on alternate days, we find out it is difficult for the patient to come at that time because of financial status. Say you are having a patient that need to be cared for dressing of wounds that must come on alternate days or on a daily basis, and you find that it is difficult for the patient to alternate those days because of finance, and sometimes hypertensive clients that need to be monitored the blood pressure, it becomes difficult for the client to come on either a weekly basis until we are sure that the blood pressure has been controlled or the client has been referred to the relevant place. The rural clinic, it is where the rural are becoming not okay to me.

Interviewer:

I heard you saying that it is not okay to working in a clinic where the patients/clients are staying far. Can you say more on this issue?

Participant:

The home-based carers are available to can assist with the dressings and follow-up of other chronic clients, but unfortunately the places that I am taking about are too far away from the clinic – about 100 kilometres and the home-based carers cannot reach those villages without a transport.

Interviewer:

Do you have any other perception to explore?

Participant:

No, I have nothing to say more.

Interviewer:

Thank you very much for your participation in the study and I still repeat that your name will not appear in any report of this to maintain anonymity.